

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**Balance Billing for Medical Equipment and  
Supplies**



**JANUARY 2001  
OEI-07-99-00510**

## **OFFICE OF INSPECTOR GENERAL**

The mission of the Office of Inspector General (OIG), mandated by Public Law 95-452, as amended by Public Law 100-504, is to protect the integrity of the Department of Health and Human Services programs as well as the health and welfare of beneficiaries served by them. This statutory mission is carried out through a nationwide program of audits, investigations, inspections, sanctions, and fraud alerts. The Inspector General informs the Secretary of program and management problems and recommends legislative, regulatory, and operational approaches to correct them.

### **Office of Evaluation and Inspections**

The Office of Evaluation and Inspections (OEI) is one of several components of the Office of Inspector General. It conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The inspection reports provide findings and recommendations on the efficiency, vulnerability, and effectiveness of departmental programs.

OEI's Kansas City office prepared this report under the direction of Brian T. Pattison, Deputy Regional Inspector General. Principal OEI staff included:

#### **REGION**

Tricia Fields, *Project Leader*  
Michael Craig, *Program Analyst*  
Zula Crutchfield, *Program Analyst*  
Joe Penkrot, *Team Leader*  
Elander Phillips, *Program Inspections Assistant*  
Marco Villagrana, *Program Analyst*  
Deborah Walden, *Team Leader*

#### **HEADQUARTERS**

Stuart Wright, *Director, Medicare and Medicaid Branch*  
Barbara Tedesco, *Mathematical Statistician*  
Scott Horning, *Program Analyst*

To obtain copies of this report, please call the Kansas City Regional Office at (816) 426-3697. Reports are also available on the World Wide Web at our home page address:

<http://www.hhs.gov/oig/oei/>

# EXECUTIVE SUMMARY

---

## PURPOSE

To determine the effects and level of Medicare beneficiary awareness of balance billing for durable medical equipment and supplies.

---

## BACKGROUND

Part B of the Medicare program covers outpatient services and items, including durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Under Medicare Part B, physicians and suppliers submit both assigned and non-assigned claims for these services and items. For assigned claims, physicians and suppliers agree to accept the amount allowed by Medicare as full payment. Medicare pays 80 percent of this amount directly to the physician or supplier and the beneficiary pays 20 percent (plus any outstanding deductible). In non-assigned claims, the physician or supplier bills the beneficiary for the total charge for the service or item provided, which can exceed the amount allowed by Medicare. Medicare pays the beneficiary 80 percent of the allowed amount; the beneficiary pays all remaining charges. We define balance billing as the portion of the charge in excess of the Medicare allowed amount.

Participating physicians and suppliers may voluntarily enter into an agreement to submit assigned claims for all services and items provided to Medicare beneficiaries. Non-participating physicians and suppliers may submit assigned or non-assigned claims on a case-by-case basis. Physicians may not balance bill in excess of 115 percent of the allowed physician fee schedule amount. However, no such limitations exist on balance billing by suppliers.

We reviewed a random sample of non-participating suppliers and non-assigned claims. We conducted telephone surveys with beneficiaries and mail surveys with suppliers. We asked beneficiaries questions about selecting their supplier, awareness of the difference between assigned and non-assigned claims and participating and non-participating suppliers, and if they compared prices and services among suppliers. Questions we asked suppliers include reasons they choose not to be a participating Medicare supplier and factors that determine whether to accept assignment.

---

## FINDINGS

### **Beneficiaries Paid \$41 Million Above the Medicare Allowed Amounts for Medical Equipment and Supplies**

As stated above, there is no limitation on balance billing by suppliers as there is for physicians. Medicare beneficiaries faced balance billing liabilities of approximately

\$41 million, \$30 million of which was above 115 percent of the Medicare allowed amounts (the limit that applies to physicians), from nearly 3 million non-assigned DMEPOS claims submitted in 1999. These claims comprise 5 percent of the number and 3 percent of the dollar amount of medical equipment and supply claims overall. Medicare beneficiaries with recurring (as opposed to one-time) needs were responsible for roughly twice the costs on non-assigned claims than those with assigned claims. For these beneficiaries, medical equipment and supplies are recurring expenses which may be incurred for the remainder of their lives. For non-assigned claims, suppliers usually require Medicare beneficiaries to pay upon delivery. One-third of surveyed beneficiaries do not have supplemental insurance that might pay for some portion of out-of-pocket expenses for these items.

### **Most Surveyed Beneficiaries Are Unaware of Differences in Assigned and Non-assigned Claims and Participating and Non-participating Suppliers**

Only two out of every five beneficiaries know that if they choose a participating supplier or a supplier that accepts assignment on a particular item, they pay only the outstanding deductible and 20 percent co-insurance. Few beneficiaries select their DMEPOS supplier based on cost considerations.

### **Sixty-two Percent of Suppliers Are Not Participating Medicare Suppliers**

More than half of the suppliers surveyed state that low reimbursement is a reason they choose not to be a participating Medicare supplier. Furthermore, 42 of these 100 suppliers also state that reimbursement levels are below cost on certain supplies.

Ostomy supplies were specifically identified by surveyed suppliers as a category of items with low or below cost reimbursement. Based on a review of 1999 claims data, we found that ostomy supplies have a higher non-assigned rate than supplies overall.

---

## **RECOMMENDATIONS**

In order to increase beneficiary access to participating suppliers and reduce financial liability for DMEPOS, we make the following recommendations to HCFA.

### **Educate Beneficiaries on Ways to Reduce Financial Liability**

We recommend that HCFA educate beneficiaries on the options and consequences of assigned and non-assigned claims and purchasing medical equipment and supplies from participating and non-participating suppliers. We suggest, for example, that HCFA direct the durable medical equipment regional carriers (DMERCs) to send an annual notice to Medicare beneficiaries for whom a non-assigned claim was submitted containing an explanation of assigned and non-assigned claims, participating and non-participating suppliers, and the availability of the Medicare Participating Suppliers Directory. Another suggestion is that HCFA direct the DMERCs to add a notation to the Medicare Summary Notice on non-assigned claims that the beneficiary may be able to reduce their financial

liability for medical equipment and supplies by purchasing from a supplier that accepts assignment on the item.

## **Re-evaluate Medicare Fee Schedules for Ostomy Supplies**

We recommend that HCFA re-evaluate the Medicare fee schedules for ostomy supplies. After receiving survey responses from 15 suppliers stating that reimbursement is very low or below cost for ostomy supplies, we conducted an analysis of 1999 claims data for these supplies. We found that ostomy supplies have a higher rate of non-assignment than DMEPOS overall, and also have a high percentage of claims submitted in excess of 115 percent of the allowed amount.

## **Other Considerations**

We offer to HCFA other suggestions that could help decrease beneficiary financial liability for medical equipment and supplies. However, these would require additional study and analysis. They include exploring ways of increasing the participation rate of suppliers, increasing beneficiary access to suppliers, and developing legislation to limit balance billing on medical equipment and supplies.

---

## **AGENCY COMMENTS**

HCFA concurred with our recommendations. HCFA stated that they have undertaken a number of efforts to increase beneficiary education and awareness about the consequences of assigned and non-assigned claims. HCFA also stated that the Participating Physician Directory is available online, and that directory will be expanded in 2001 to include supplier information.

HCFA stated that it will continue to explore options to increase beneficiary awareness. We suggest that HCFA consider, as one of these options, a more direct approach to reach Medicare beneficiaries who purchase medical equipment and supplies from non-participating suppliers that submit non-assigned claims, such as an annual notice and/or a notation on the Medicare Summary Notice for a non-assigned claim.

HCFA stated that it is committed to examining the payment for ostomy supplies once it has published a final rule concerning its inherent reasonableness authority. We note that HCFA could evaluate the appropriateness of the fee schedules while waiting for the issuance of the final rule.

# TABLE OF CONTENTS

	PAGE
<b>EXECUTIVE SUMMARY</b> .....	i
<b>INTRODUCTION</b> .....	2
<b>FINDINGS</b>	
Beneficiaries Paid \$41 Million in Balance Billing .....	6
Beneficiaries Unaware of the Differences .....	9
Majority of Suppliers Are Not Participating .....	9
<b>RECOMMENDATIONS</b> .....	12
<b>APPENDICES</b>	
A: Confidence Intervals for Key Estimates .....	15
B: Agency Comments .....	16

# INTRODUCTION

---

## PURPOSE

To determine the effects and level of Medicare beneficiary awareness of balance billing for durable medical equipment and supplies.

---

## BACKGROUND

Part B of the Medicare program covers outpatient services and items, including durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). DMEPOS include medical equipment and supplies such as wheelchairs, hospital beds, catheters, ostomy and wound care supplies, and enteral and parenteral nutrition. In 1999, Medicare Part B paid an estimated \$6.2 billion for medical equipment and supplies.

### Suppliers

Medicare only pays for DMEPOS that are prescribed or ordered by a physician. The Medicare beneficiary then selects a supplier from which to rent or purchase the item. Types of suppliers include: discount retail chains such as Wal-Mart, home medical equipment businesses and pharmacies, and mail order companies. Suppliers can be large corporations or small proprietorships. Some suppliers sell only medical equipment and supplies, while others sell a wide variety of merchandise of which DMEPOS comprise a small percentage of total sales for the retailer.

### Assigned and Non-assigned Claims

Under Medicare Part B, suppliers submit both assigned and non-assigned claims. For assigned claims, suppliers agree to accept the amount allowed by Medicare as full payment. Medicare pays 80 percent of this amount directly to the supplier and the beneficiary pays 20 percent plus any outstanding deductible. In non-assigned claims, the supplier bills the beneficiary for the total charge for the service or item provided, which can exceed the amount allowed by Medicare. In 1999, 5 percent of DMEPOS claims were submitted non-assigned, equating to approximately 3 million claims and allowed charges of \$160 million. For these claims, Medicare pays the beneficiary 80 percent of the allowed amount, less any deductible not yet met. The beneficiary must pay the supplier directly the amount billed irrespective of the allowed amount. We define balance billing as the portion of the charge in excess of the Medicare allowed amount.

### Durable Medical Equipment Regional Carriers

In October 1993, the Health Care Financing Administration (HCFA) began processing Part B claims for medical equipment and supplies through four durable medical equipment regional carriers (DMERCs). Each DMERC processes durable medical

equipment claims for a specific geographic region and ensures that all coverage requirements for medical equipment and supplies are met before approving payment. Any HCFA directives to change payment processing for DMEPOS claims are implemented through the DMERCs.

## **Medicare Participation Program**

The Deficit Reduction Act of 1984 established a participating physician and supplier program for Medicare Part B, under which a physician or supplier may choose whether or not to become a “participating” Medicare physician or supplier on an annual basis. Participating physicians and suppliers voluntarily enter into an agreement to accept assignment for all services and items they provide to Medicare beneficiaries. Non-participating physicians and suppliers may submit assigned or non-assigned claims on a case-by-case basis, but must accept assignment whenever a Medicare beneficiary also has Medicaid coverage.

Each DMERC publishes a Medicare Participating Suppliers Directory (MEDPARD) which lists the name, business address, and telephone number for each participating supplier in its region.

## **Limiting Charges and Balance Billing**

Currently, physicians who are non-participating Medicare physicians receive only 95 percent of the Medicare allowed amount; however, they may bill up to 115 percent of this amount. This limit protects Medicare beneficiaries from excessive balance billing on non-assigned claims. As of January 1999, 85 percent of physicians billing Medicare were participating physicians.

Suppliers are not subject to limits on balance billing for medical equipment and supplies. There are no limits on the amount suppliers can charge beneficiaries, nor is there a reduction in payments to non-participating suppliers.

## **Payment for Upgraded Equipment**

While Medicare will pay for items that are adequate and effective to meet the medical needs of the beneficiary, it will not pay extra for convenience or luxury features. For example, Medicare will pay for eyeglass frames, wheelchairs, and hospital beds which meet the medical needs of the beneficiary. However, Medicare will not pay for upgraded versions that cost in excess of Medicare allowed amounts for items such as premium eyeglass frames and total electric hospital beds.

Currently, a participating Medicare supplier or a supplier that accepts assignment on the item must accept the allowed amount as full payment for the upgraded item. If a supplier wishes to charge and collect a greater price for upgraded DMEPOS, they must be a non-participating supplier and submit a non-assigned claim. Medicare then pays the beneficiary 80 percent of the allowed amount, less any outstanding deductible. The

beneficiary is then responsible to the supplier for the full payment price of the upgraded item.

On April 27, 2000, HCFA issued a proposed rule for comment regarding the payment procedure for upgraded equipment. The proposed rule would amend the Medicare regulations to permit suppliers to furnish upgrades while still submitting an assigned claim. Medicare would pay the supplier the allowed amount for the standard item less 20 percent co-insurance and any outstanding deductible, and the beneficiary would pay the difference between the supplier's charge for the upgraded item and 80 percent of the allowed amount for the standard item.

---

## METHODOLOGY

To determine the effects and level of Medicare beneficiary awareness of balance billing, we reviewed non-participating suppliers and non-assigned claims. We selected a stratified random sample of 150 (plus 150 spares) non-assigned DMEPOS claims from a 1 percent sample of the Medicare Part B National Claims History file for the period September 1 - November 30, 1999. This gave us a sample of beneficiaries along with the suppliers that provided medical equipment or supplies to these beneficiaries.

We contacted beneficiaries or their caregivers associated with 150 claims.<sup>1</sup> As shown in the table on the following page, we chose 50 of the claims with the submitted amount between 101 and 115 percent of the allowed amount. The remaining 100 claims had the submitted amount in excess of 115 percent of the allowed amount. The 115 percent threshold was chosen because it is the limit in effect for physician services. We chose a larger sample size for claims submitted in excess of 115 percent of the allowed amount because these items were of greater interest in our study.

---

<sup>1</sup> We used 23 spares in stratum 1 and 60 spares in stratum 2 to replace beneficiaries that did not respond after multiple attempts to contact them. We also replaced seven claims that were identified as assigned claims during the survey process.

Strata	Universe of Non-assigned claims	Number of claims in 1 percent file	Supplier-Claim Combinations	Sample Size
1. Claims for procedure codes for which the submitted amount is between 101% and 115% of the Medicare allowed amount	601,090	1,198	100	50
2. Claims for procedure codes for which the submitted amount is in excess of 115% of the Medicare allowed amount	1,117,839	2,213	200	100

Some beneficiaries had more than one claim in the sample. Therefore, we surveyed 138 different beneficiaries or caregivers, representing 150 claims. We asked the beneficiaries and caregivers questions regarding the reasons they selected their supplier, their awareness of the difference between assigned and non-assigned claims and participating and non-participating suppliers, and whether they compared prices and services among suppliers. We also asked about the method of payment for their supply or equipment, how often they purchased it, and whether it was a recurring expense for the beneficiary.

Out of 300 supplier-claim combinations, 27 claims were dropped for administrative reasons; for example, some claims were submitted by beneficiaries that received their DMEPOS from suppliers that do not possess a Medicare provider identification number (some beneficiaries choose to purchase from suppliers that do not have the capacity to bill Medicare directly). We surveyed the remaining sample of 273 supplier-claim combinations by mail and received 216 responses (79 percent) representing 176 unique suppliers. We asked questions on the type of equipment and supplies provided, the reasons the supplier chose not to be a participating Medicare supplier, and factors that determined whether to accept assignment on a particular claim. We also asked the suppliers to estimate the percentage of claims they bill non-assigned and requested copies of supplier billing and payment information for the sample of beneficiary claims to determine the amount balance billed to the beneficiary and the amount collected by the supplier.

We systematically analyzed the survey responses from Medicare beneficiaries and medical equipment suppliers. We calculated confidence intervals for seven key estimates in the report. The point estimate and 95 percent confidence interval for each estimate are listed in Appendix A of this report.

We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

# FINDINGS

## Beneficiaries paid \$41 million above the Medicare allowed amounts for medical equipment and supplies

Medicare beneficiaries experience greater financial liability on non-assigned claims than assigned claims because suppliers can bill more than the Medicare allowed amount on non-assigned claims. There is no limitation on balance billing by suppliers as there is for physicians. Projected from claims in the 1999 1 percent file, Medicare beneficiaries faced balance billing liabilities of approximately \$41 million, \$30 million of which was above 115 percent of the Medicare allowed amounts (the limit that applies to physicians), from nearly 3 million non-assigned DMEPOS claims. These claims comprise 5 percent of the number and 3 percent of the dollar amount of medical equipment and supply claims overall.

### High volume, low cost items predominate

We arrayed the non-assigned claims in the 1 percent file from highest to lowest frequency. The table below identifies the items comprising the top 50 percent of claims in terms of frequency along with the total and average amount suppliers balance billed for these items. Projected to the universe of non-assigned claims, the five items account for 22 percent of the total amount balance billed in 1999.

Top 50 Percent of Claims Frequency Projected from the 1999 1 Percent File <sup>2</sup>				
Item	HCFA Billing Code	Number of Claims	Total Balance Billing	Average Balance Billing per Claim
Glucose testing strips	A4253	887,000	\$3,152,708	\$3.55
Bifocal lenses	V2203	154,400	\$1,952,556	\$12.65
Lancets	A4259	148,900	\$178,270	\$1.20
Ostomy wafers (protective skin barrier)	A5123	134,500	\$735,852	\$5.47
Eyeglass frames	V2020	114,400	\$3,137,511	\$27.43

<sup>2</sup> The frequency and dollar projections are based on the billing codes submitted for the claims. Multiple HCFA billing codes exist for items similar to the above (e.g., additional billing codes exist for bifocal lenses).

## Few claims have high balance billing

We also arrayed the non-assigned DMEPOS claims based on highest average balance billing per claim. Projected to the universe of non-assigned claims, these 6,100 claims account for \$4,919,524 in balance billing, or 12 percent of the total dollars balance billed for claims submitted in 1999. The table below identifies the items balance billed in excess of \$500 in terms of frequency along with the total and average amount suppliers balance billed for these items.

<b>Claims Balance Billed in Excess of \$500 Projected from the 1999 1 Percent File</b>				
<b>Item</b>	<b>HCFA Billing Code</b>	<b>Number of Claims</b>	<b>Total Balance Billing</b>	<b>Average Balance Billing per Claim</b>
Desferal injection, (deferroxamine mesylate)	J0895	500	\$995,120	\$1,990.24
Flolan injection, (epoprostenol)	J1325	1,000	\$172,440	\$1,724.40
Oxygen concentrator	E1404	600	\$694,270	\$1,157.12
Above knee prosthetic	L5320	100	\$109,093	\$1,090.93
Power operated vehicle	E1230	1,800	\$1,575,922	\$875.51
Prosthetic eye	V2623	1,000	\$804,621	\$804.62
Infusion pump for epoprostenol	K0455	100	\$67,253	\$672.53
Motorized wheelchair with programmable controls	K0011	1,000	\$500,805	\$500.81

Note: This table, like the previous one, is based on a simple projection of the 1 percent file. Some estimates are based on a very small number of claims.

## Sampled claims reflect the universe

Our sample is reflective of the universe of DMEPOS claims with balance billing. Over one-half of our claims have balance billing amounts under \$10. The table on the next page shows the amount of balance billing per claim for the 150 claims in our sample.

Amount of Balance Billing per Claim	Number of Claims in Sample	Distribution of Claims
less than \$5	60	40%
between \$5 and \$10	25	17%
between \$10 and \$20	34	23%
between \$20 and \$50	20	13%
between \$50 and \$100	6	4%
between \$100 and \$200	4	3%
greater than \$300	1	less than 1%
Total	150	100%

### **Most non-assigned claims are for recurring needs**

In our survey, we asked beneficiaries to identify the claim(s) as either a one-time or recurring expense. We found that 84 percent of non-assigned claims are for recurring needs. Beneficiaries for 35 percent of these recurring non-assigned claims report ordering the item monthly or more frequently. Examples of these items include ostomy supplies and diabetic testing supplies. For these beneficiaries, these supplies are recurring expenses which may be incurred for the remainder of their lives.

Medicare beneficiaries with recurring needs are responsible for roughly twice the costs on non-assigned DMEPOS claims than the beneficiaries with assigned claims. The average financial liability per claim for non-assigned recurring claims is \$16.73. If these claims had been assigned, the beneficiaries would have had an average of \$8.50 financial liability. At a minimum, this amounts to \$98.73 more per year financial liability per claim for these beneficiaries. Each beneficiary, on average, had responsibility for 39 percent of the allowed amount per claim, as opposed to 20 percent liability (plus any outstanding deductible) on the allowed amount for an assigned claim.

Examples of items for the remaining 16 percent of non-assigned claims that beneficiaries identified as a one-time expense include eyeglass frames and lenses, breast prostheses, and walkers. While we did not ask the beneficiaries whether or not they considered these items to be “upgraded,” eyeglass frames and lenses and ambulatory aids such as walkers have the potential to include convenience or luxury features.

### **Suppliers expect immediate payment from Medicare beneficiaries**

Beneficiaries experience a lag time in reimbursement from Medicare and supplemental insurance companies for non-assigned claims. However, for non-assigned claims, suppliers commonly require Medicare beneficiaries to pay for DMEPOS upon delivery. The beneficiary then awaits reimbursement from Medicare and any supplemental

insurance companies. One-third of surveyed beneficiaries report that they do not have supplemental insurance that might pay some portion of out-of-pocket expenses (e.g., co-insurance and deductible) for DMEPOS.

---

## **Most surveyed beneficiaries are unaware of differences in assigned and non-assigned claims and participating and non-participating suppliers**

Because Medicare beneficiaries are unaware of the differences in assigned and non-assigned claims and participating and non-participating suppliers, they may not understand the financial consequences of their decisions. Only 44 percent of beneficiaries we surveyed know there are differences in financial liability between assigned and non-assigned claims. Only 41 percent know that if they choose a participating supplier or a supplier that accepts assignment on a particular item, they pay only 20 percent co-insurance, plus any outstanding deductible. At the conclusion of our telephone surveys, some beneficiaries remarked that they had never thought about the potential to save money by purchasing from a participating supplier or one that accepts assignment on the item.

### **Few beneficiaries select their DMEPOS supplier based on cost considerations**

Medicare beneficiaries may be able to limit their financial liability by comparing prices among suppliers. Less than one-third of the surveyed beneficiaries compare prices and services among suppliers before purchasing supplies or equipment. Forty-four percent of the beneficiaries (61 of 138) state that the close proximity of the supplier to their residence was a factor in their decision to select a supplier. Forty-one percent (57 of 138) conducted business with the supplier in the past and chose to select that supplier again for the sampled claim. Also, 14 percent (20 of 138) of the surveyed beneficiaries state that they chose their supplier because it was the only supplier in their area which provided the particular item. Some beneficiaries also said they chose their supplier based on a recommendation of medical personnel.

---

## **Sixty-two percent of suppliers are not participating Medicare suppliers**

According to the Statistical Analysis Durable Medical Equipment Regional Carrier, which compiles and analyzes national claims history data for equipment and supplies, 62 percent of suppliers were not participating Medicare suppliers for claims submitted with dates of service in 1999. These non-participating suppliers submitted 66 percent of DMEPOS claims, although only 5 percent of all claims were non-assigned. The rate of non-participation has increased each year since 1996 when 55 percent of suppliers did not

participate. We found no particular concentration of non-participating Medicare suppliers in a geographic area.

### **Surveyed suppliers cite low reimbursement as a reason for non-participation**

Fifty-seven percent (100 of 176) of the suppliers surveyed (i.e., suppliers that submitted at least one non-assigned claim during the sample period) state that low reimbursement is a reason they choose not to be a participating Medicare supplier. Of these 100 suppliers 42 also state that reimbursement levels are below cost on certain supplies (we did not independently verify suppliers' responses and, therefore, cannot attest to whether reimbursement is indeed below cost). When projected to the universe of non-assigned claims, 56 percent of non-assigned claims are linked to suppliers who report that low reimbursement is a reason to not become a Medicare participating supplier. Other reasons cited by suppliers include difficult bookkeeping or inadequate staffing for collections from beneficiaries and time lags in receiving reimbursement from Medicare and supplemental insurance companies. Some suppliers also state that beneficiaries desire additional quantities or premium products not approved by Medicare.

As stated previously, we reviewed non-participating suppliers and non-assigned claims. Sixty-one percent of surveyed suppliers estimate that they bill non-assigned on at least half of their Medicare claims. Twenty-seven percent bill non-assigned on every Medicare claim. When projected to the universe of non-assigned claims, 57 percent of claims are submitted by suppliers that bill non-assigned on at least half of their Medicare claims. One explanation for the rate of non-assignment being so high for some suppliers may be that the nature of business for large discount retail chains is payment at the time of sale rather than awaiting future reimbursement.

### **Claims for ostomy supplies have a higher non-assigned rate than supplies overall**

As noted earlier, 5 percent of all claims were submitted non-assigned in 1999. In contrast, for the ostomy supplies group, 29 percent of Medicare claims were submitted non-assigned. Of the 5 percent of claims submitted as non-assigned, 38 percent have the submitted amount in excess of 115 percent of the allowed amount. Ostomy supplies have 61 percent of claims with the submitted amount in excess of 115 percent of the allowed amount, although they account for only approximately 20 percent of non-assigned DMEPOS claims.

In our mail survey, we asked suppliers to list the factors that determine whether to bill a particular item assigned or non-assigned. Fifteen suppliers specifically volunteered that ostomy supplies reimbursement is either low or below cost. One supplier provided an example of low reimbursement on ostomy pouches shown on the following page.

HCPCS A5063	
Manufacturer's Suggested Retail Price	\$27.40
Medicare allowed amount	\$21.30
Less: Cost of supply from distributor	\$20.18
Overhead and claim processing	<u>\$ 5.25</u>
Loss to supplier	- \$ 4.13

In this case, the supplier submitted a non-assigned claim and charged the beneficiary \$27.40.

# RECOMMENDATIONS

Medicare beneficiaries incur financial liability for durable medical equipment and supplies. Many beneficiaries also purchase items on a recurring basis that may be used for the remainder of their lives. In some cases, the financial liability may be a hindrance to beneficiaries receiving medical equipment and supplies they need. The majority of surveyed beneficiaries are not aware of the differences between assigned and non-assigned claims and participating and non-participating suppliers. Having such an understanding may increase beneficiary access to participating Medicare suppliers and decrease their financial liability. As such, we make the following recommendations to HCFA.

---

## Educate beneficiaries on ways to reduce financial liability

Medicare beneficiaries can decrease their financial liability for medical equipment and supplies by purchasing from a participating supplier or a supplier that accepts assignment on a particular item. We recommend that HCFA educate beneficiaries on the options and consequences of assigned and non-assigned claims and purchasing medical equipment and supplies from participating and non-participating suppliers. We suggest, for example, that HCFA direct the DMERCs to send an annual notice to Medicare beneficiaries for whom a non-assigned claim was submitted containing an explanation of assigned and non-assigned claims, participating and non-participating suppliers, and the availability of the Medicare Participating Suppliers Directory. Another suggestion is that HCFA direct the DMERCs to add a notation to the Medicare Summary Notice on non-assigned claims that the beneficiary may be able to reduce their financial liability for medical equipment and supplies by purchasing from a supplier that accepts assignment on the item.

---

## Re-evaluate Medicare fee schedules for ostomy supplies

After receiving survey responses from fifteen suppliers stating that reimbursement is very low or below cost for ostomy supplies, we conducted an analysis of 1999 claims data for these supplies. We found that ostomy supplies have a higher rate of non-assignment than DMEPOS overall, and also have a high percentage of claims submitted in excess of 115 percent of the allowed amount. We understand that HCFA is committed to examining the payment for ostomy supplies once it has published a final rule concerning its inherent reasonableness authority. We note that HCFA could evaluate the appropriateness of the fee schedules while waiting for the issuance of the final rule.

---

## Other Considerations

In addition to the above recommendations, HCFA may want to consider ways to increase the participation rate of suppliers, increase beneficiary access to suppliers, and limit excessive balance billing to help decrease beneficiary financial liability for medical equipment and supplies. We recognize these are complex problems, and may require additional study and analysis.

In 1999, 85 percent of physicians billing Medicare were participating physicians. This percentage has gradually increased since 1996. In contrast, only 38 percent of suppliers participated in 1999, with a trend of decreasing participation since 1996. As stated earlier, non-participating suppliers submitting non-assigned claims commonly require beneficiaries to pay for medical equipment and supplies upon delivery. Beneficiaries then experience a lag time in reimbursement from Medicare and supplemental insurance companies. Purchasing from a participating supplier alleviates the lag time, because the supplier bills the beneficiary only the outstanding deductible and 20 percent co-insurance. Then the supplier awaits reimbursement from Medicare and supplemental insurance companies.

We note that, currently, non-participating physicians receive 95 percent of the Medicare allowed fee schedule amount. Implementing a 5 percent reduction in payments to non-participating suppliers could provide some incentive for suppliers to participate. This would require passage of legislation.

As previously noted, some surveyed beneficiaries state that they chose their supplier because it was the only supplier in their area which provided the particular item. In order to improve beneficiary access to participating suppliers, HCFA could explore ways to increase access to other suppliers (e.g., suppliers which accept mail order).

Another seemingly logical option for decreasing beneficiary financial liability for medical equipment and supplies might be to develop legislation to institute limiting charges on them. Since January 1, 1993, charges for physician services have been limited to 115 percent of the Medicare allowed amount. This limit protects beneficiaries from excessive balance billing on non-assigned claims. We recognize that while on the surface such legislation for medical equipment and supplies could be beneficial, there may be potential negative outcomes (e.g., beneficiaries may not be able to purchase upgraded items, or suppliers may choose not to offer items on which they lose money).

---

## Agency Comments

HCFA provided written comments to this report, the full text of which are included in Appendix B. HCFA concurred with our recommendations.

**Educate beneficiaries on ways to reduce financial liability**--HCFA agreed that educating beneficiaries is of utmost importance. HCFA stated that it has undertaken a number of efforts to increase beneficiary education and awareness of assigned and non-assigned claims, such as:

- ▶ publishing a pamphlet entitled, “Does your doctor or supplier accept assignment?”,
- ▶ discussing the importance of acceptance of assignment by doctors and suppliers as it relates to cost savings in several pages of the booklet entitled “Medicare & You 2001”, and
- ▶ posting an online Participating Physician Directory containing the names, addresses, and specialties of Medicare participating physicians who have agreed to accept assignment.

HCFA stated that the directory will be expanded in 2001 to include supplier information, and that they will continue to explore options to increase beneficiary awareness. We suggest that HCFA consider, as one of these options, a more direct approach to reach Medicare beneficiaries who purchase medical equipment and supplies from non-participating suppliers that submit non-assigned claims, such as an annual notice and/or a notation on the Medicare Summary Notice for a non-assigned claim.

**Re-evaluate Medicare fee schedules for ostomy supplies**--HCFA stated that it is committed to examining the payment for ostomy supplies once it has published a final rule concerning its inherent reasonableness authority. We note that HCFA could evaluate the appropriateness of the fee schedules while waiting for the issuance of the final rule.

## Confidence Intervals for Key Estimates

---

We calculated confidence intervals for seven key estimates. The point estimate and 95 percent confidence interval are given for each of the following:

Key Estimate	Point Estimate	Confidence Interval
Claims linked to suppliers who report low reimbursement is a reason not to become a Medicare participating supplier	56%	+/-7%
Claims submitted by suppliers that bill non-assigned on at least half of their Medicare claims	57%	+/-7%
Claims submitted for beneficiaries who state the DMEPOS are recurring expenses which will be incurred for the remainder of their lives	84%	+/-6%
Recurring expense claims for which beneficiaries report ordering monthly or more frequently	35%	+/-8%
Mean financial liability to beneficiary for claims recurring monthly or more frequently	\$16.73	+/- \$3.72
Mean financial liability to beneficiary for claims recurring monthly or more frequently, if assigned	\$8.50	+/- \$2.25
Yearly per claim financial liability to beneficiary for claims recurring monthly or more frequently	\$98.73	+/- \$23.11

## **Agency Comments**

---

In this appendix, we present comments from the Health Care Financing Administration.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of the Administrator  
Washington, D.C. 20201

JAN 5 2001

DATE:

TO: June Gibbs Brown  
Inspector General

FROM: Robert A. Berenson M.D.  
Acting Deputy Administrator

*Robert A. Berenson*

RECEIVED  
2001 JAN -5 PM 3:53  
OFFICE OF INSPECTOR  
GENERAL

SUBJECT: Office of Inspector General (OIG) Draft Report: "Balance Billing for Medical Equipment and Supplies," (OEI-07-99-00510).

Thank you for the opportunity to review the above-mentioned draft report. The Health Care Financing Administration (HCFA) agrees with the OIG's recommendation that educating beneficiaries on ways to reduce financial liability is extremely important.

Over the past year, HCFA has undertaken a number of efforts to increase beneficiary education and awareness about the consequences of assigned and unassigned claims. HCFA has created a Medicare pamphlet entitled "Does your doctor or supplier accept assignment?" The pamphlet is available in English, Spanish, Braille, and audiotape and is used in beneficiary outreach seminars. It is available to view and download on [www.medicare.gov](http://www.medicare.gov), and copies are available by calling 1-800-MEDICARE. Also, *Medicare & You 2001* was sent to 34 million beneficiary households this fall. Several pages of *Medicare & You 2001* discuss the importance of acceptance of assignment by doctors and suppliers as it relates to cost savings. "Medicare and You 2001" also refers readers to the above Medicare pamphlet for more detailed information.

As part of the ongoing effort to provide Medicare beneficiaries with information to help them make health care choices, HCFA launched an online Participating Physician Directory at [www.medicare.gov](http://www.medicare.gov), HCFA's beneficiary Website. The directory was released on November 15, 2000 and is accessible from the home page under the section titled Participating Physician Directory. The directory contains names, addresses, and specialties of Medicare participating physicians who have agreed to accept assignment. The directory will be expanded in 2001 to include supplier information.

HCFA will continue to explore your suggestions, as well as other cost effective alternatives, in our efforts to educate Medicare beneficiaries on ways that they can decrease the financial liability for medical equipment and supplies. We will also re-evaluate the Medicare fee schedules for ostomy supplies.

✓  
\_\_\_\_\_  
JAS  
\_\_\_\_\_  
IG-OI  
IG-MH  
\_\_\_\_\_  
✓  
1-5-01

OIG Recommendation

HCFA should educate beneficiaries on ways to reduce financial liability.

HCFA Response

We concur. Educating beneficiaries is of utmost importance. However, as mentioned earlier we have several educational materials already ready that help beneficiaries understand this issue. Obtaining adequate funding for our current educational programs has been challenging at times and may also need to be addressed in the future to ensure the continuance of the National Medicare Education Program.

OIG Recommendation

HCFA should re-evaluate the Medicare fee schedules for ostomy supplies.

HCFA Response

We concur. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 precluded HCFA from using its inherent reasonableness (IR) authority until the GAO could publish its report, and HCFA could publish a final rule addressing the GAO concerns. Once HCFA publishes a final IR rule, we have committed to examining the payment for ostomy supplies.

OIG Recommendation

HCFA should explore ways of increasing the participation rate of suppliers.

HCFA Response

We concur with the general suggestion that HCFA should explore ways of increasing participation rates for both physicians and suppliers. Given that 95% of provider claims are accepted on assignment, we do not believe we need to devote significant resources for a national campaign to increase participation for DME suppliers. However, we will consider other options and will continue to monitor the issue so that beneficiaries may have increased access to these suppliers.